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A. TYPE OF HANDBOOK

Part R, Vision Care Services, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part R includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement rates, and billing instructions. Part R is to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. PROVIDER INFORMATION

Provider Eligibility and Certification

For certification as a provider in the WMAP under HSS 105.32, Wis. Admin. Code, optometrists must be licensed and registered pursuant to ss. 449.04 and 449.06, Wis. Stats. Opticians wishing to be certified as WMAP providers under HSS 105.33, Wis. Admin. Code must practice as described in s. 449.01(2), Wis. Stats. Physicians (ophthalmologists) who want to participate under HSS 105.05, Wis. Admin. Code, must be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14. Optometrists, opticians, and ophthalmologists practicing outside Wisconsin, but who provide services to WMAP recipients, must meet the licensing and registration requirements of their own states.

Scope of Service

The policies in Part R govern services within the scope of the practice of the profession as defined in s. 449.01, Wis. Stats., and HSS 107.20, Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

Optometrists and ophthalmologists may be reimbursed by the WMAP for services related to dispensing and repair of vision materials, as well as for covered diagnostic services. Optometrists with a Therapeutic Pharmaceutical Agents (TPA) certificate and ophthalmologists may be reimbursed for certain surgical procedures. Opticians may be reimbursed by the WMAP only for services pertaining to the supply, dispensing, and repair of eyeglasses. Refer to Appendix 1 of this handbook for a list of allowable procedure codes for vision providers. Ophthalmologists may be reimbursed for additional procedure codes not listed in this handbook, and are referred to the Physician Handbook, Part K, for additional information on covered services.

The State Purchase Eyeglass Contract (SPEC) contractor may be reimbursed by the WMAP for materials covered by the SPEC which are dispensed by WMAP-certified vision providers. Ophthalmologists, optometrists, and opticians may be reimbursed only for materials which are not covered under the SPEC and have been prior authorized by the WMAP.

Refer to Section II of this handbook for information on the SPEC and to Section III of this handbook for information on prior authorization.

Reimbursement

Optometrists, opticians, and ophthalmologists are reimbursed at the lesser of the provider's usual and customary charges or the maximum allowable fee established by the Department of Health and Social Services (DHSS) for these services.

Items/materials which are not available through the SPEC (including emergency vision items purchased out-of-state) are reimbursed at no more than the average wholesale cost of the materials. Refer to Section II of this handbook for more information on the SPEC.

B. PROVIDER INFORMATION (continued)

Provider Responsibilities

Specific responsibilities as a WMAP provider are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility for Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The Medical Assistance identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage. The recipient must be eligible on the date that any services are rendered, including the ordering of replacement parts or eyeglasses.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and eligibility verification. Section V of Part A of the WMAP Provider Handbook must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of Part A of the WMAP Provider Handbook for additional information regarding medical status.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining vision care services. The procedure codes and their applicable copayment amounts are listed in Appendix 1 of this handbook.

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payment allowed by the WMAP. Providers should not reduce the billed amount of the claim by the amount of recipient copayment.

Providers must not collect copayment for the following:

- Services provided in an emergency circumstance;
- Services provided to nursing home residents;
- Services provided to recipients under 18 years of age;
- Services provided to a pregnant woman if the services are related to the pregnancy;
- Services covered by a WMAP-contracted managed care program to enrollees of the managed care program.

C. RECIPIENT INFORMATION (continued)

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, and 22a of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

The managed care program is responsible for providing all vision care services to recipients enrolled in WMAP-contracted managed care programs, including materials. For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement, provision of vision items/materials, and prior authorization for vision services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX-E of Part A of the WMAP Provider Handbook.

A. INTRODUCTION

Section II of this handbook describes basic coverage and limitations on vision procedures in the Wisconsin Medical Assistance Program (WMAP). Providers must familiarize themselves with this section in order to ensure that only covered services are rendered in compliance with all appropriate guidelines. Appendix 1 of this handbook contains a complete listing of all covered services.

Optometrists may be reimbursed for all procedures listed except that only TPA-certified optometrists may be reimbursed for procedures requiring TPA certification. Opticians may be reimbursed only for procedures pertaining to the dispensing and repair of eyeglasses.

Ophthalmologists may be reimbursed by the WMAP for all procedures listed in Appendix 1 of this handbook as well as WMAP-covered services identified in the Physician's Current Procedural Terminology (CPT). Ophthalmologists are referred to the Physician Handbook, Part K, for additional information on covered services.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC)

Under the State Purchase Eyeglass Contract (SPEC), all vision care providers certified in the WMAP must order all WMAP-covered eyeglasses and component parts directly from the provider contracted with the Department of Health and Social Services (DHSS) to supply those services.

Effective with orders placed on and after April 1, 1995, Precision Optics is the SPEC contractor. The address for the SPEC contractor is:

The Omega Group
Precision Optics, Incorporated
Box 1228, 6925 Saukview Drive
St. Cloud, MN 56302

Procedures for Ordering Materials

Vision care providers must order materials from the SPEC contractor on an order form supplied by the SPEC contractor. For SPEC billing information, refer to Section IV-E of this handbook.

Properly ordered materials, except in unforeseen or unusual circumstances, are expected to be shipped to providers by the SPEC contractor within six working days of receipt of the order. Providers should allow for mailing time for orders and materials when calculating an expected delivery date. If an order is not received within 14 days, providers should telephone the SPEC contractor. To expedite processing of orders, please type or clearly print all orders accurately and completely. Illegible orders will require additional processing time to clarify or return.

If within 30 days of delivery any material is found by the dispensing provider to be unsatisfactory due to the SPEC contractor's error, defective workmanship, or materials, the provider should return the materials and order form to the contractor. The SPEC contractor is required to adjust, correct, or replace the materials at the SPEC contractor's expense. The SPEC contractor is not liable for the cost of replacement orders required due to errors made by the prescribing or dispensing provider, nor for defective materials not reported within 30 days of delivery.

SPEC Lenses

The SPEC includes glass, plastic, and polycarbonate lenses for single vision, multifocal, and cataract lenses. Contracted lenses must conform to the American National Standards Institute (ANSI) recommendation for prescription of ophthalmic lenses, ANSI Z80.1 - 1979, and the Food and Drug Administration (FDA) requirements for impact resistant lenses. Providers should refer to Appendix 2 of this handbook for a list of lenses covered under the SPEC.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC) (continued)

SPEC Frames

The SPEC includes frames which meet ANSI Z80.5 - 1979 Standards. (Refer to Appendix 3 of this handbook for a list of SPEC-covered frames).

WMAP vision care providers must purchase a sample kit of SPEC frames. Sample kits are available from the contractor. Providers will not be reimbursed for materials included in sample kits. A sample kit can be ordered by writing to the SPEC contractor.

Ordering Partial Appliances

If a recipient requires new lenses only, the dispensing provider must, whenever possible, send the recipient's existing frames to the SPEC contractor with the lens order. Orders received by the contractor as "frame enclosed" must include:

- the actual frame or a machine-made pattern (not a hand tracing) with the order, if the frame enclosed is a new frame; or
- the actual frame, if the frame enclosed is a used frame. Hand tracings or drawings are not acceptable.

Orders without the frame enclosed, or without a pattern for a new frame, may be returned to the ordering provider within three working days of receipt of the order with a written explanation as to why the order was not processed.

The lenses are then mounted in the recipient's frame. If, in the opinion of the SPEC contractor, the lenses cannot be mounted without damage to the frames, the SPEC contractor may either return the frames with the unmounted lenses to the provider with a written explanation why the lenses were not mounted; or contact the provider by telephone so the provider may order a complete appliance from the SPEC contractor.

If a recipient has a metal frame, the frame must accompany the order for lenses.

If the recipient requires a new frame only, and the recipient's lenses do not fit a SPEC frame, a complete appliance must be ordered from the SPEC contractor.

Non-Contracted Materials/Out-of-State Providers/Out-of-State Foster Children

Prior authorization is required for all non-contracted vision items and for eyeglasses, frames, lenses, and components billed for out-of-state foster children and out-of-state providers. Please refer to Section III of this handbook for prior authorization requirements and to Section IV for billing instructions.

C. EVALUATION AND DIAGNOSTIC SERVICES

Evaluation and Management Services

Evaluation and Management, New Patient

The WMAP defines "new patient" as a patient who is new to the provider and whose medical and administrative records need to be established. The WMAP interprets this to be a new patient to either the physician or clinic. The WMAP allows one new patient procedure per recipient, per performing or billing provider, per lifetime.

Evaluation and Management, Visits

Only one office visit is allowed per date of service for a new or established patient, per performing provider.

C. EVALUATION AND DIAGNOSTIC SERVICES (continued)

Ophthalmological Examinations
A refraction is not separately reimbursable with an ophthalmological examination as this procedure is included in the reimbursement for the examination. Refer to Section IV-B of this handbook for instructions on billing for refractions for dual entitlees.

A comprehensive ophthalmological examination for an established patient may be reimbursed once per recipient, per performing provider, per 12-month period without prior authorization. Additional comprehensive exams, if medically necessary, may be reimbursed if they have been prior authorized. (Refer to Section III of this handbook for prior authorization requirements.)

Low Vision Eye Examination
The WMAP covers one low vision examination per recipient per year. Prior authorization is required for low vision examinations.

Supplemental Tests
Supplemental tests are included in the reimbursement rate set for comprehensive or low vision examinations and are not reimbursed separately on the same date of service as a comprehensive examination or low vision examination. Refer to Appendix 1 of this handbook for information on which tests are not separately reimbursable.

D. DISPENSING AND REPAIR SERVICES

Dispensing Fees
The WMAP covers dispensing fees for furnishing contracted materials to recipients. The dispensing fee includes selecting, ordering, and dispensing contracted materials. Dispensing fees associated with non-SPEC materials are not covered by the WMAP unless the non-SPEC materials and dispensing fee have been prior authorized by the WMAP. All dispensing fees include routine follow-up and post-prescription visits for minor adjustments. The date of service used for billing purposes is the date of order of the eyeglasses. Only one dispensing fee is allowed per date of service.

Dispensing Complete SPEC Appliances
This procedure is covered when both a SPEC frame and SPEC lenses have been ordered (unifocal, bifocal, or trifocal). Only one pair and one replacement from the same prescription per 12-month period are covered unless prior authorization is obtained for additional services. (Refer to Section III of this handbook for prior authorization requirements.)

Dispensing SPEC Frames
This procedure is not covered when billed on the same date of service as dispensing a complete appliance, temple replacement, or lens replacement.

Dispensing SPEC Temple or Temples
This procedure is not covered when billed on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing SPEC Lens or Lenses
This procedure is not covered when a SPEC lens(es) has been ordered (either unifocal or multifocal), on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing a Complete Appliance or Lens(es) with a Changed Prescription
Providers may be reimbursed by the WMAP for dispensing one additional complete appliance or lens(es) without prior authorization when there is a documented change in the lens prescription of more than +/-.50 diopter in the spherical or cylinder power and a cylinder axis shift of greater than 10 degrees.

D. DISPENSING AND REPAIR SERVICES (continued)

Repair Service

This procedure is covered for minor repairs (e.g., new hinge, rivet, solder). Repair services beyond the 30-day warranty period are not a part of the SPEC and are not required to be ordered from the SPEC contractor. Repair services may be ordered through the lab of the ordering provider's choice, if not performed in the provider's office. Routine follow-up and post-prescription visits (for minor adjustments) are considered part of the initial dispensing fee and are not covered as repair services. However, an order that is unacceptable due to defects in materials, workmanship, or due to a processing error, must be returned to the SPEC contractor within 30 days of delivery for repair.

Date of Service

The date of service for billing the dispensing of eyeglass frames or lenses is the date the vision provider orders the materials, not the date the order was received by the SPEC contractor, nor the date the service obtained prior authorization, if required, nor the date the recipient obtains the materials. When ordering replacement materials from an existing prescription, the date of service is the date the replacement is ordered. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider. Vision providers are responsible for verifying that the recipient is eligible on the date of service.

E. COVERED VERSUS NONCOVERED VISION MATERIALS

The WMAP reimburses vision providers only for covered materials listed in this handbook, when prior authorization and other requirements are met. A provider may provide a service which includes a noncovered portion. The provider may bill the recipient directly for the noncovered portion of the service only if the covered and noncovered portions of the service are distinctly separate and the recipient has been notified in advance and has agreed to pay separately for the noncovered portion. For example, a provider may order covered eyeglasses through the SPEC for a recipient, and may charge the recipient for the noncovered anti-glare coating or fashion tint that the recipient requests. This is allowable since the anti-glare coating or fashion tint may be added later as a separate procedure.

A provider may not, however, seek reimbursement from the WMAP for a noncovered service by charging the WMAP for a covered service which was not provided, and applying the reimbursement toward a noncovered service. For example, if a recipient chooses to receive photogrey lenses which have not been prior authorized, the provider may not bill the WMAP for lenses of any type and bill the recipient for the difference between the WMAP reimbursed amount and the actual cost of the service. In this instance, the entire lens is considered noncovered by the WMAP, because photogrey is an integral part of the lens and cannot be provided as a separate service.

Refer to Section IV of Part A of the WMAP Provider Handbook for information on recipient requests for noncovered services and provider acceptance of payment.

F. PRESCRIPTIONS

Requirements of Prescriptions for Drugs

Ophthalmologists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients. Optometrists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients if they hold a Therapeutic Pharmaceutical Agents (TPA) certificate. Before using or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a Drug Enforcement Administration (DEA) certification of registration. The WMAP does not reimburse providers separately for any charges associated with writing prescriptions.

F. PRESCRIPTIONS
(continued)

Prescription Requirements

Except as otherwise noted in federal or state law, a prescription must be in writing or given orally and later reduced to writing and must include the following information:

- name of drug or service prescribed
- directions for use of the prescribed drug or item
- prescriber's name and address
- recipient's name and address
- date of the order
- prescriber's signature

E. **PRESCRIPTIONS** (continued)

Prescriptions for any Schedule II, III, IV, or V pharmaceutical agents must also contain the Drug Enforcement Agency (DEA) number of the prescriber.

For hospital and nursing home recipients, orders must be entered into the medical and nursing charts and must include the information listed above. Services ordered by prescription must be provided within one year of the date of the prescription.

"Brand Medically Necessary" Requirements

In order for a pharmacy to be reimbursed for a drug at a rate higher than that allowed for a generic equivalent, the prescribing provider must certify that a brand name drug is medically necessary by using the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY."

This certification must be in the prescribing practitioner's own handwriting directly on the prescription order or on a separate authorization which is attached to the original prescription. Pharmacy orders must have this documentation prior to submitting claims to the WMAP. Prescriptions which indicate "No Substitutes" or "N.S." are not covered by the WMAP, and claims for these services are denied. The prescriber must also document in the recipient's medical record the reason why the brand drug is medically necessary.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. "Blanket" authorization for an individual recipient, drug, or prescriber is not acceptable documentation. A letter of certification is acceptable as long as the notation is handwritten and is for specified drugs for an individual patient. While it is the pharmacy's responsibility to have this written documentation, it is the prescriber's responsibility to provide the pharmacy with the required documentation.

Nursing Home Orders

Prescriber certification that the brand is medically necessary must be made on each prescription order written for nursing home residents. This certification is good only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

Drug Rebate System

The drug rebate system is the result of the federal Omnibus Budget Reconciliation Act of 1990. Under the drug rebate system, drug manufacturers that choose to participate in state Medical Assistance programs are required to sign rebate agreements with the federal Health Care Financing Administration (HCFA). Participation in the Medical Assistance program is voluntary on the part of the drug manufacturers. Rebate agreements are valid for one year. At the end of one year, manufacturers may choose whether or not to continue participation in the rebate program. Non-participating manufacturers have the option each quarter of signing a rebate agreement which will be effective the following quarter.

Manufacturers that have signed rebate agreements have their prescription drugs covered by the WMAP if the drugs meet WMAP guidelines. For manufacturers that did not sign a rebate agreement, the WMAP does not cover drugs produced by the manufacturer, except as noted in Appendix 12 in this handbook. The prescriber may wish to contact a local WMAP-certified pharmacy to confirm the WMAP coverage status of a particular drug or product.

E PRESCRIPTIONS (continued)

Appendix 12 of this handbook is a list of the types of drugs that are covered by the WMAP, including those which require prior authorization. Appendix 13 of this handbook lists noncovered drugs, including drugs sold by manufacturers that did not sign rebate agreements.

Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement

The WMAP recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer that did not sign a rebate agreement. These drugs may be provided to the recipient when the pharmacy completes a prior authorization request.

The prescriber must provide the following documentation to the pharmacy in the above instance:

- A statement indicating that no other drug produced by a manufacturer that signed a rebate agreement is medically appropriate for the recipient.
- A statement indicating that WMAP coverage of the drug is cost effective for the WMAP.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber demonstrating medical necessity.

G NONCOVERED SERVICES

The following services and items are not covered under the WMAP:

1. Services and items requiring prior authorization for which authorization has been either denied or not requested. If a provider fails to request prior authorization for a service which requires prior authorization, the recipient may not be billed.
2. Dispensing services related to noncovered items.
3. Eyeglass cases.
4. Spare eyeglasses.
5. Tinted lenses for non-medical reasons.
6. Anti-reflection coating.
7. Services or items provided principally for cosmetic reasons, including gradient focus or progressive bifocals, fashion or cosmetic tints, engraved lenses, and anti-scratch coating.
8. Charges for telephone calls.
9. Charges for missed appointments.
10. Consultations between or among providers.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Reimbursement is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service and may not bill the recipient.

Providers are advised that prior authorization does not guarantee reimbursement. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medical Assistance Program (WMAP) requirements, must be met prior to reimbursement of the claim.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

The services listed below require authorization from the WMAP prior to delivery:

1. Vision training and therapy, including orthoptics and pleoptics.
2. Contact lenses and contact lens therapy except when the diagnosis is aphakia or keratoconus or when therapeutic or bandage contact lenses are required.
3. Low vision services and aids for all diagnostic conditions.
4. Aniseikonic services.
5. Eyeglass frames and lenses beyond the original and one unchanged prescription replacement pair (either a complete appliance or a lens replacement or a frame replacement dispensed on different dates of service) from the same provider in a 12-month period.
6. Ptosis crutch services and materials.
7. Contracted occupational safety frames and lenses.
8. Tinted eyeglass lenses (contracted tints and coatings including rose #1 and rose #2, ultraviolet coating, and photochromic lenses).
9. Special lens designs and components (contracted high index glass and plastic, polycarbonate lenses for recipients age 21 and over, large eye size 59mm or over).
10. Comprehensive vision examinations beyond the initial comprehensive vision examination within a 12-month period.
11. Frames and lens materials which are not obtained through the WMAP State Purchase Eyeglass Contract (SPEC).

C. PRIOR AUTHORIZATION FOR NON-CONTRACTED MATERIALS

Contact Lenses

Contact lenses are not part of the SPEC. A prior authorization request for contact lens approval must identify the lens material and specifications as well as materials costs. If the recipient has a diagnosis of keratoconus (diagnosis code 371.6) or aphakia (diagnosis code 379.3) or if the contacts are being used as a therapeutic or bandage lens (procedure code 92070), then prior authorization is not required.

C. PRIOR AUTHORIZATION FOR NON-CONTRACTED MATERIALS (continued)

Low Vision Aids

Low vision aids are not part of the SPEC. When submitting prior authorization requests for low vision aids, specify the type of aid and power as well as the material costs.

Special Lenses and Frames

The dispensing provider must submit a prior authorization request to EDS which documents the medical necessity of special lenses or tints or for occupational frames. A copy of the approved prior authorization form must be sent with the order to the SPEC contractor. A diagnosis of photophobia is not sufficient for approval of tints without additional justification of medical need by the prescribing provider.

Prior authorization for dispensing of non-contracted frames may be approved if medically necessary (e.g., for recipients allergic to plastic or requiring exceptional frame adjustments for cataract lenses). However, the lenses must still be ordered from the SPEC contractor. Refer to Appendix 1 of this handbook for the appropriate procedure codes.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Optometrists and ophthalmologists who determine that a recipient needs services requiring prior authorization should submit a Prior Authorization Request Form (PA/RF) and Prior Authorization Vision Services Attachment (PA/VA) to the EDS Prior Authorization Unit.

Refer to Appendices 6, 7, 8, and 9 of this handbook for sample prior authorization forms and completion instructions.

E. PROCEDURES AND SERVICES PRICED AT PRIOR AUTHORIZATION

The WMAP establishes the maximum reimbursement amount for certain procedures and services when the PA/RF and PA/VA are processed. Refer to Appendix 1 of this handbook for a list of procedures and services which are priced at prior authorization.

Submitting the Prior Authorization Request Form (PA/RF)

PA/RFs for procedures priced at prior authorization must be submitted using the following procedures and services:

- Prior authorization for procedures requiring more than one item should list each item, with a procedure code description, on a separate line on the PA/RF. The items must be individually identified on the PA/RF with complete and specific descriptions and prices from the manufacturer.
- Do not include a modifier in element 15.
- Indicate a quantity of "1" in element 19 of the PA/RF. If dispensing a pair of items, indicate "pair" in the description and include the cost of the pair in element 20 of the PA/RF.

Receiving an Approved PA/RF

When an approved PA/RF is returned to the provider, the maximum amount that will be reimbursed when the claim is submitted is indicated on the PA/RF. If several items are approved under one procedure code, a procedure code modifier (numbers 11-22) is assigned by the WMAP consultant in element 15 for each approved item. Refer to Section IV of this handbook for information on billing for procedures priced at prior authorization.

E. PROCEDURES AND SERVICES PRICED AT PRIOR AUTHORIZATION (continued)

Submitting Amendments to An Approved PA/RF

If the average wholesale cost increases for an item priced at prior authorization, a provider may obtain a higher level of reimbursement than is identified on the PA/RF only by submitting a prior authorization amendment request. The amendment must document that the wholesale cost has increased.

If an amended PA/RF is approved after the claim is paid, a claim adjustment request for additional reimbursement may be submitted which indicates that the amount approved at prior authorization has been changed. Refer to Section IX of Part A of the WMAP Provider Handbook for information about adjustment requests.

F. OBTAINING AND SUBMITTING PRIOR AUTHORIZATION REQUEST FORMS

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

G. BACKDATING PRIOR AUTHORIZATION

Under normal circumstances, prior authorization must be obtained before services are performed to receive WMAP reimbursement for vision services. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed on an emergency basis, retroactive prior authorization may be obtained. Refer to Section VIII of Part A of the WMAP Provider Handbook for additional information on retroactive prior authorization.

Approved prior authorization requests for lenses or frames will be backdated to the date the requesting provider signs and dates the PA/RF.

The grant date for all other prior authorization requests will be no earlier than the date the request is received by EDS.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report." Refer to the claim form completion instructions in Appendix 4 of this handbook for health insurance indicator codes.

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Dual Entitlees

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare and Medicare has denied the service, a Medicare disclaimer code must be indicated on the claim. Refer to the claim form completion instructions in Appendix 4 of this handbook.

Billing for Medicare Noncovered Refractions

The refraction portion of a comprehensive vision exam is not paid by Medicare, nor can Medicare forward it to the WMAP for payment. However, refractive services for dual-entitlees which are not covered by Medicare are reimbursable by the WMAP.

In order to obtain Medical Assistance reimbursement for refractions for dual entitlees, providers must do the following:

- Complete and submit a claim to Medicare (using standard Medicare billing procedures) for the comprehensive exam; including the information necessary for all crossover claims. Medicare will cross over the claim to EDS for coinsurance and deductible;
- Complete and submit a HCFA 1500 claim form directly to EDS for Medicare noncovered refractive services;
- Indicate "M-8" ("Not a Medicare Benefit") in element 11 of the HCFA 1500 claim form; and
- Indicate procedure code 92015 in element 24D.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary-only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and deductible for Medicare-covered services. (Since Medicare covers some vision services, claims submitted for QMB-only recipients are reimbursed for Medicare-covered services.) Refer to Section V of Part A of the WMAP Provider Handbook for instructions on how to identify QMB-only recipients.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient. Providers must bill for materials not covered under the State Purchase Eyeglass Contract (SPEC) at actual wholesale cost.

D. BILLED AMOUNTS (continued)

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 4 of this handbook for complete claim form completion instructions.

E. ORDERING THROUGH STATE PURCHASE EYEGLASS CONTRACT (SPEC)

Order Form Requirements
Order forms submitted to the SPEC contractor by mail or FAX must include:

- The date of order.
- The name, address, and eight-digit Medical Assistance provider number of the dispensing provider.
- The name, address, birthdate, sex, and complete 10-digit Medical Assistance identification number of the recipient.
- A copy of the approved prior authorization request form for all services requiring prior authorization.
- All other pertinent prescription detail.

Please make certain that all information is accurate and legible to ensure that orders are processed correctly and in a timely manner.

Ordering SPEC Frames or Temples
The name of the contracted frame or temple(s) must be specified on the order form submitted to the SPEC contractor.

Ordering SPEC Lenses
The complete lens formula of the contracted lenses must be specified on the order form submitted to the SPEC contractor.

Recipients must have a current Medical Assistance identification card for all orders submitted, including orders for replacement parts. The recipient must be eligible on the date of order. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider.

All orders must be submitted to the SPEC contractor in writing or by FAX. No telephone orders are accepted. Order forms must be signed by the dispensing provider or an authorized representative.

Orders for managed care program enrollees should be handled according to the terms of the managed care program contract.

F. NON-CONTRACTED MATERIALS

Ordering Non-Contracted Lenses and Frames
All non-contracted materials require prior authorization. Orders for prior authorized non-contracted materials may be placed with any vendor of the provider's choice, and do not have to be obtained through the SPEC contractor. Refer to Appendices 2 and 3 of this handbook for a list of lenses and frames provided by the SPEC contractor.

Billing for Non-Contracted Lenses and Frames
Claims for non-contracted materials must indicate procedure codes V2799 ("non-contracted materials") or W8190 ("dispensing non-contracted materials, and other miscellaneous services") in element 24C of the HCFA 1500 claim form.

G. BILLING FOR EVALUATION AND MANAGEMENT PROCEDURE CODES AND CONSULTATIONS

Evaluation and Management Procedure Codes

Claims submitted by optometrists for the highest level evaluation and management procedure codes and unlisted medical procedures (92499) require documentation describing the procedure performed. All claims for these procedure codes must be submitted on paper claims. The provider must write "See Attached" in element 19 (Reserved for Local Use) of the HCFA 1500 claim form and attach additional documentation justifying the level of service billed. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the WMAP medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for these medical procedures which do not have sufficient documentation attached to the claim, or for which the documentation does not substantiate the complex level of medical practice being billed, are denied. Refer to Appendix 1 of this handbook for procedure codes requiring documentation.

Other Evaluation and Management Services

Evaluation and Management CPT procedure codes in the ranges 99201-99285 and 99301-99353 may be billed only when the patient encounter does not include a surgical procedure code. If a surgical procedure is performed, the provider is reimbursed on the basis of the procedure performed, not on the basis of an evaluation and management visit.

Consultations

Claims for consultations must indicate the referring physician's name in element 17, and the referring physician's UPIN number, WMAP provider number, or license number in element 17a of the HCFA 1500 claim form.

H. BILLING FOR PROCEDURES PRICED AT PRIOR AUTHORIZATION

Claims for procedures which are priced at prior authorization must be submitted on the HCFA 1500 claim form with:

- a quantity of "1" for each item; and
- the specific modifier from element 15 on the approved PA/RF on the claim form when billing for procedures which are assigned a modifier.

Refer to Section III of this handbook for information on procedures priced at prior authorization.

I. BILLING FOR UNLISTED PROCEDURE CODES

Claims for unlisted procedures (92499) require documentation describing the procedure performed. The provider may use element 19 (Reserved for Local Use) of the HCFA 1500 claim form, if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "See Attached" in element 19 and attach additional documentation. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for unlisted medical procedures which do not have documentation either on the claim or attached to the claim are denied.

J. LABORATORY TESTS

Laboratory Tests

Optometrists and ophthalmologists may be reimbursed for laboratory tests billed as a "complete" procedure or for the professional component only. A complete lab test includes both the professional and technical components. A vision provider may not be reimbursed for the technical component of a laboratory test only.

J. LABORATORY TESTS (continued)

Laboratory Test Preparation and Handling Fees

If an optometrist or ophthalmologist performs both the professional and technical components of a laboratory test, the vision provider is reimbursed for the complete procedure. In this instance, a handling fee is not paid.

If a vision provider obtains a specimen and refers it to an outside laboratory for analysis or interpretation, the outside laboratory is reimbursed for the complete procedure. The vision provider may bill only for a handling fee using the handling fee procedure code.

Additional limitations on billing handling fees are:

1. One lab handling fee is paid per provider, per recipient, per outside laboratory, per date of service, regardless of the number of specimens sent to the laboratory. One handling fee is paid only when "yes" is indicated for outside laboratory in element 20 of the HCFA 1500 claim form.
2. When billing handling fees for specimens sent to two or more laboratories for one recipient on the same date of service, indicate the number of laboratories in the units field in element 24G and the total charges in element 24F of the HCFA 1500 claim form.
3. Claims for a lab handling fee which do not have "yes" checked for outside lab in element 20 of the HCFA 1500 claim form are denied.

Clinical interpretations of lab tests are not separately billable, since interpretations are reimbursed within the payment for the recipient's visit.

K. CLAIM SUBMISSION

Paperless Claim Submission

EDS encourages submission of claims on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Claim processing statistics demonstrate that providers submitting electronically reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Paper claims for vision care services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions can be found in Appendices 4 and 5 of this handbook.

Paper claims for vision care services submitted on any form other than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

K. CLAIM SUBMISSION (continued)

Completed paper claims submitted for reimbursement must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing appeals can be found in Section IX of Part A of the WMAP Provider Handbook.

L. DIAGNOSIS CODES

All diagnoses must be from the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Refer to Appendix 10 of this handbook for a listing of frequently used diagnosis codes for vision care services.

M. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all HCFA 1500 claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes, their descriptions and allowable modifiers for vision services are included in Appendix 1 of this handbook.

N. MODIFIERS

Procedure code modifiers may be used to indicate that a service or procedure has been modified by a specific circumstance relative to a procedure performed. A maximum of two valid modifiers may be used for each procedure code. Refer to Appendix 1 of this handbook for a list of allowable procedure codes and modifiers. Only those modifiers listed in this handbook are recognized by the WMAP for vision services. Refer to the Current Procedural Terminology, Fourth Edition (CPT-4) for a complete description of allowable modifiers.

O. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures